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Gordon (S.C.)

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at Parturition.

A PAPER

READ BEFORE THE

Maine Medical Association,

JUNE 13, 1883,

Presented

BY S. C. GORDON, M. D.,
OF PORTLAND.



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Report of the Committee on the
Education of the Blind

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Results of Treatment of Injuries Occurring at Parturition.

Since the publication of MARION SIMS' "Uterine Surgery," giving the results of his operations upon the various injuries caused by childbirth, the profession has been to a great degree familiar with what has been accomplished in repairing the lacerated perineum, in closing vesico-vaginal fistulæ, and many other serious troubles that arose therefrom. SIMS' speculum and "SIMS' position," together with the general use of the silver wire suture, mark the beginning, in surgical diseases of women, of an era of the most brilliant character. The inventive genius of EMMET, the indefatigable zeal and industry of THOMAS, the profound researches of that most eminent pathologist and skillful surgeon, PEASLEE, together with a host of others, have given to gynecological surgery an impetus scarcely equalled in any department of our profession. THOMAS, with his usual generosity, in his writings says: "If all that SIMS has done for gynecology were suppressed, we should find that we had retrograded at least a quarter of a century."

So familiar, therefore, is every student of medicine with the results of most of the operations upon the female genital organs, that it would seem but a waste of time to add anything more, in a paper before this Association. Almost every practitioner who lays any claim to surgical skill thinks himself perfectly competent to perform the various operations of perineorrhaphy, elytrorrhaphy, and those for relief of vesico-vaginal and the other forms of fistula, lacerated cervix, etc., etc. The current literature of the profession is filled with reports of cases, and new methods of performing the operations, each man striving for some new "dodge." A lacerated perineum or cervix

seems a proper field for operation, whether there be any other demand for it than the mere fact that it exists. An operation is made, the case is numbered among the trophies of the gynecologist, and we hear no more. The patient may be relieved of the suffering, or she may be a patient or an impatient sufferer still. I believe the time has come to call a halt in this direction and sum up the results. Let us call in the reports from the army of operators, and find how the account of human suffering and relief stands. Let our reports show, not how many cases we have operated upon, but how many we have operated upon for a specific purpose, and what percentage of cures we have effected; and, what is of as much or more consequence to the younger members of the profession, how many failures we have recorded, and, as far as we are able, what are the causes of those failures. Let us also inquire, as definitely as may be, what is the important purpose of many of these operations.

Perhaps the most frequent and important of these various operations is that of perineorrhaphy—certainly the most frequently made, and doubtless the most important, when made for certain purposes and properly performed. The accident of laceration of the perineum is the foundation of so many future troubles, immediate and remote, that we can well consider it the prime factor in a large majority of the results which the gynecologist is called upon to treat. First, it is the most important element in arrest of involution of all the parts concerned in parturition, viz: vagina and uterus. Add to this a lacerated cervix, and you have sufficient cause for hyperplasia of uterus, a lax vagina; and as an almost necessary consequence, soon or late, there follows cystocele, rectocele, prolapsus and retroversion of the uterus, urethral and cystic irritation, complicated, oftentimes, with vaginismus, hemorrhoids, fissure of the anus, to say nothing of passive congestion, with all its sequelæ of vegetations of the uterus, metrorrhagia and leucorrhœa. Years may elapse ere this entire train of symptoms appear, and yet, in by far the larger proportion of cases, we can trace the sequel of symptoms from the parturition that caused the perineal laceration. A state of chronic invalidism marks the history from that time until the patient comes to our hands. Oftentimes, too, we find that she has been treated in various ways, and

by a variety of practitioners, for the several symptoms enumerated. The list of general and local remedies has been endured, but no permanent relief comes, for the cause and its effects still remain, and only a temporary relief is given, or, what is worse, she is made very much more an invalid in consequence of treatment. In many of these cases, we find a condition of pelvic exudate, or passive congestion, as a result of former inflammations or interference with the circulation, by displacements, so that any manipulations upon the uterine canal, or stimulating applications to any part thus affected, is almost sure to light up a fresh attack of pelvic inflammation, from which the patient recovers only after a long period of rest and careful management. In all this class of cases, "meddlesome medication" is always bad, and the last state is far worse than the first.

Given, then, a case with hyperplasia of a uterus, retroverted, mobile to the full extent, with lax vagina, and an almost necessary accompaniment of cystocele or rectocele, what shall be the *modus operandi* of cure? First, I would treat the uterus as I would an enlarged tonsil, by removing a portion of it, and thereby establish the process of fatty degeneration and absorption. If there be present lacerated cervix, operate for closure of that; if no laceration exists, remove a V from each side of the cervix, as high up as the vaginal junction. Do not hesitate to make this operation upon a liberal scale. Most cases of hyperplasia admit of considerable tissue being removed. Be sure that it is neatly done, by a single stroke of the scissors for the half of either side. With the utmost care, close the wound by as few sutures as will thoroughly graft the surfaces and *absolutely control hæmorrhage*. *At the same time*, put the uterus in position and adjust a well-fitting retroversion pessary, and wait a week, directing copious warm or hot water injections at least twice a day, to ensure cleanliness and stimulate the absorbent process. If everything goes well, at the end of this time the operation for cystocele may be made. I much prefer the oval denudation to any other, removing all that can be spared, and admit complete closure of the mucous membrane, without strain upon the tissues. Be sure that no hæmorrhage occurs behind the flaps, or the operation will be a failure. At this

operation, the sutures must be removed from the cervix. Another week, with similar treatment, and the case is ready for the final operation of perineorrhaphy, which is to restore the perineal body, cure the rectocele, and *bring the posterior vaginal wall in contact with the anterior one, thus shortening this wall* and giving support to the uterus, bladder and all the parts displaced. Before doing this, the sutures are to be removed from the cystocele and the pessary withdrawn. And just here let me suggest that this removal of the pessary must be done with the utmost care, so that the uterus shall not be disturbed and displaced. I deem this indispensable, for in many cases I find that, if no immediate displacement takes place, *a complete cure of the retroversion follows; it never becomes displaced afterwards. The shortening of the vaginal wall and the shutting of the vagina completely imprisons the uterus*, so that there is no room for the change of its axis. Should this occur in spite of these precautions, advantage must be taken of the first opportunity, after the wound of the perineal operation has sufficiently healed to bear manipulation, to replace the organ, and support by the pessary, until the process of involution of the uterus and vagina, now so well started, shall be complete. I believe the accomplishment of this (involution) is by far the most important result to be aimed at in perineorrhaphy. Unless we can cure the retroversion, we have failed to obtain the benefit from the operation that the patient expects. Her symptoms are not relieved, except when the pessary is worn, and she fails to find sufficient reward for all the suffering and anxiety attendant upon what seems to her, a formidable operation. The general complaint among practitioners is, that pessaries do not *cure* displacements, especially in women who have borne children. In a majority of cases this is true, and much of the contempt for them (pessaries) has justly arisen from failure in this respect. Only so long as the instrument is worn does the patient experience any relief, and many become discouraged by the inconveniences, to say nothing of the sufferings caused by repeated attempts to properly adjust them to each particular case, and the disagreeable irritation which often results from their long-continued use. My experience in these various operations justifies me in the assertion that the only certain cure

for these long standing cases of retroversion is in this manner, and that for *this purpose*, if no other, we should advise the operations.

We all know, when once the process of fatty degeneration is set up in any of the hyperplastic parts, how rapidly it goes on. A simple illustration has already been given in removal of a portion of the tonsil, and the uterus and vagina are no exceptions to the rule; therefore, I make this operation upon each of them for that reason alone, even if there be no lacerated cervix or very much destruction of the perineal body. In cases when it becomes necessary to apply the pessary, after the operations fail to produce immediate cure of the displacement, the patient should be instructed to follow the hot douche, while this should be supplemented by frequent glycerine packs, with the view to complete the process of involution as rapidly as possible, while the pessary should be removed at least every two weeks, and allowed to remain out for two days. As soon as possible, a smaller one should be substituted for the first one used, so that no undue distension be exerted upon the vagina. Astringent medication of the glycerine packs assists materially in the curative process.

These minor details may seem trivial and commonplace, but they are by no means non-essentials. In my own experience, they are the potent factors in procuring the result aimed at and to be desired, viz: *permanent cure of retroversion*. Without attention to these several details, we find ourselves where we commenced, the result unattained, and the patient hopelessly discouraged. On the other hand, a patient, persevering, careful and intelligent management of these cases will satisfy any one that a *majority* of them can be entirely and permanently relieved, so that no longer shall retroversion be the "bête noire" of gynecology.

I believe that there is much yet to be learned as to the proper time and manner of making these various operations. EMMET has very properly laid great stress upon having the patient suitably prepared for any of these operations upon the female genitalia. His important point of caution is with reference to the condition of the pelvic viscera and connective tissue. While I am fully in accord with the sentiments inculcated in this respect, I feel sure that

oftentimes much time is lost in *vain* attempts to get rid of all pelvic tenderness and passive congestion. I am sure that, do what we may, so long as the *neuralgic point* attendant upon a lacerated cervix exists, we are losing time until we operate for its removal. Once *thoroughly* removed, the pelvic congestion passes away, and the sufferer is relieved. I have seen cases treated for months, and no change occur until the thorn is removed. While I would not advise any operative interference with any active inflammatory process existing, I am satisfied that too many cases have been allowed to continue to suffer through fear of pelvic cellulitis. If very much care is exercised in handling the uterus (not putting too much strain upon it), experience teaches me that the free hæmorrhage, caused by the proper performance of trachelorrhaphy, is the best remedy for the passive congestion of the pelvic tissues. Much more harm may be, and often is, done by the so-called "preparatory treatment," in the hands of unskillful practitioners.

All cysts of the cervix should be carefully destroyed as rapidly as possible, while the hot douche should be freely and systematically used in the meantime, together with such general treatment as may seem indicated, but the delay need not be for any long period, for the inflammatory process is a short one, if acute, and the *effects* of inflammation will remain so long as the uterus continues neuralgic; therefore remove the cause, and the effect ceases. The bugbear of pelvic inflammation has had too much control with experienced practitioners, in my opinion. To younger men, "make haste slowly" is a most judicious rule of practice.

I formerly postponed all operative interference so long as there seemed to be any special pain, referable to the pelvis or pelvic organs, but recently, I find that in many cases this is unnecessary, and, in some, I should never have operated at all had I waited for the indication. The greatest care, however, should be taken to distinguish pain of a neuralgic form from that due to inflammation or congestion of an active character. The operation frequently relieves the former, while it may develop an acute attack in the latter condition. One thing is of paramount importance, viz: that all fungous growths, and causes that have contributed to produce, and may tend to keep up afterwards, menorrhagia or metrorrhagia,

should be most thoroughly removed before operating for lacerated cervix. Catarrh of the cervix should also be entirely relieved. The uterus should be allowed a period of rest from local manipulations for a long period after such an operation. Plain and medicated glycerine packs and the hot douche may be continued, but all harsher means are mentioned only to be deprecated.

In perineorrhaphy, there is one caution to be observed, the lack of which has caused many a patient to regret having had it performed. I allude to the use of too many sutures. In my own practice, I have found several cases where the vaginal passage was too small, and coitus necessarily painful. This is no unimportant matter, but one that we are bound to regard. If the last suture is carried up through the undenuded mucous membrane, thereby drawing the posterior wall down and covering the wound, and by so much shortening the vagina, we obtain a perineal body sufficiently strong and thick, without closing the vulva so high as to interfere with the proper sexual relation. After no one of these operations do I allow the catheter to be used, unless the patient is unable to evacuate the bladder. The use is almost sure to produce more or less cystitis, which continues, in many instances, for months. Neither do I allow the bowels to become constipated, much less take measures to check them. They should be kept soluble, so that no fecal impaction shall occur.

An additional word in regard to the operation for lacerated cervix. The operation is not made simply for the laceration. The fact alone that such a condition exists may not be sufficient to urge an operation, although, where any ectropion occurs, I believe all are justified in operating to prevent epithelioma. By far the most important point aimed at is to relieve the actual neuralgic pain through the pelvis and back, as well as to cure the nervous symptoms that follow from the long-continued irritation. Now, barely closing this laceration, so that the parts unite, is by no means a sure relief to these troubles; unless it be done thoroughly and properly, the last state of that woman is far worse than the first.

I stated, at the beginning of this paper, that we must have a definite object in view whenever we attempt any of these operations. I have made this operation, and have seen it made many

times more, when not only was the patient not relieved, but actually made worse—all the symptoms were aggravated. EMMER has placed great stress upon the removal of the cicatricial tissue from the angle. Of equal importance, in my opinion, is the removal of *all* the cicatricial tissue the *entire length of the laceration*. Merely eroding the surfaces, as is so often done, while it may permit the surfaces to adhere, only unites two *neuralgic* surfaces, and the pain is increased. A clean, deep cut, symmetrical throughout, is an imperative necessity. A rough, uneven, ragged surface, is worse than letting the patient alone.

I could cite cases illustrative of these various operations, but I deemed it best to present the matter to you in this way, believing that the general principles involved in the whole question would be of more interest.

In conclusion, I can only say that in all the various operations for accidents occurring at childbirth, I have *never* had a fatal result; and whenever I have failed to accomplish all I desired, I could almost always trace it to a violation of some one of the principles or minor details herein described.

DISCUSSION

Dr. BRACKETT asked how a case of pure retroversion was to be cured.

Dr. GORDON said never by pessaries alone, but, when there is hyperplasia, by lateral section of the cervix.

Dr. GORDON stated, in answer to a question, that when he made trachelorrhaphy and perineorrhaphy at the same time, he used for the cervix sutures of catgut, and for the perineum, wire; when only one operation is made, always uses wire; when catgut is used for the cervix, his practice is to make an extra knot.

He guarded against impaction by keeping the bowels loose throughout.

He would not provoke cystic irritation by invariable use of the catheter, but would use it if necessary. Preferred a celluloid catheter for use in these cases to any other.

Dr. WEDGEWOOD asked what advantage the oval method of operation for cystocele had over the triangular method.

Dr. WEEKS said that he frequently met with cases in women nulliparous, married and unmarried, which go to demonstrate that the uterus never impregnated does become hypertrophied, notwithstanding EMMET's denial. He would favor EMMET's modification of SIMONS' operation, not only to close the wound, but to increase interstitial absorption as well.

Dr. GORDON believed that the time had arrived to collect statistics of the results of labor upon these cases after operation. He replied to Dr. WEDGWOOD that he favored the oval-shaped incision, because he believed the presence of the triangular flap left by the V-shaped incision to be the cause of failure in many cases, and the triangular incision was unsymmetrical, and the edges would not come together so smoothly.

Dr. HERR asked if, in very severe and obstinate cases, we could count on complete success.

Dr. GORDON believed we could with certainty.

